HEALTH CARE FOR THE HOMELESS

HEARING

BEFORE THE

SUBCOMMITTEE ON
HEALTH AND THE ENVIRONMENT

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

ON

H.R. 3789

A BILL TO AMEND THE STEWART B. McKINNEY HOMELESS ASSISTANCE ACT TO EXTEND PROGRAMS PROVIDING URGENTLY NEEDED ASSISTANCE FOR THE HOMELESS, AND FOR OTHER PURPOSES

JUNE 15, 1990

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CONTENTS

HEALTH CARE FOR THE HOMELESS

FRIDAY, JUNE 15, 1990

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:45 a.m., in room 2123, Rayburn House Office Building, Hon. Henry Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order.

Our hearing this morning is on the reauthorization of the four health care for the homeless programs funded under the McKinney Act.

Two days ago, the Committee on Banking, Finance, and Urban Affairs order reported H.R. 3789, the McKinney Homeless Assistance Act Amendments of 1990. This legislation would revise and extend all of the McKinney homeless programs through fiscal year 1992.

Next week I expect that this subcommittee will take up title V of H.R. 3789, which extends the health care for the homeless programs through fiscal year 1992. The purpose of this hearing is to lay the groundwork for that markup by reviewing the achievements of these programs to date.

The homeless may no longer be front page news, but they are still out in the streets in large numbers. And they are at great risk for a wide range of severe health problems, including tuberculosis, HIV infection, hypertension and diabetes, among others.

To meet the health needs of this hard-to-reach population, this subcommittee in 1987 authored the health care for the homeless program. Building on a successful foundation-funded demonstration, this program, known as the "340" program, makes grant funds available to public and private nonprofit organizations to deliver primary care and substance abuse treatment services to homeless people.

In 1989, the health care for the homeless program funded 109 projects in 103 cities and 43 States. These projects served over 352,000 homeless patients that year. About 40 percent of those served were children and their parents, or runaway youths. Sixty percent were minorities.

Clearly, the health care for the homeless program has made a major contribution to meeting the severe health needs of the homeless. And just as clearly, the need in urban and rural communities for the services delivered by the "340" program far exceeds the

supply. I am hopeful that this morning's witnesses will tell us how this program can be strengthened and expanded to respond even more effectively to the health care needs of the homeless.

I want to ask unanimous consent that the record remain open so all members will have an opportunity to insert an opening statement should they wish to.

[Testimony resumes on p. 14.]

[The text of H.R. 3789 follows:]

101ST CONGRESS
1ST SESSION

H. R. 3789

To amend the Stewart B. McKinney Homeless Assistance Act to extend programs providing urgently needed assistance for the homeless, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 20, 1989

Mr. VENTO (for himself, Mr. GRAY, Mr. GONZALEZ, Mrs. ROUKEMA, Mr. HAWKINS, Mr. KILDEE, Mr. WAXMAN, Mr. RANGEL, Mr. DOWNEY, Mr. CONYERS, Mrs. COLLINS, Mr. ACKERMAN, Mr. APPLEGATE, Mr. ATKINS, Mr. AUCOIN, Mrs. BOXER, Mr. CARPER, Mr. CLAY, Mr. CROCKETT, Mr. DEFAZIO, Mr. DICKS, Mr. DURBIN, Mr. DWYER of New Jersey, Mr. EDWARDS of California, Mr. FAUNTROY, Mr. FAZIO, Mr. FEIGHAN, Mr. FLAKE, Mr. FOGLIETTA, Mr. FRANK, Mr. FROST, Mr. GILMAN, Mr. HAYES of Illinois, Mr. HUBBARD, Mr. KANJORSKI, Ms. KAPTUR, Mr. KENNEDY, Mrs. KENNELLY, Mr. KOSTMAYER, Mr. LANTOS, Mr. LEHMAN of California, Mr. LEVINE of California, Mr. LEWIS of Georgia, Mr. MCDERMOTT, Mr. MANTON, Mr. MARKEY, Mr. MARTINEZ, Mr. MFUME, Mr. MILLER of Washington, Mrs. MORELLA, Mr. NEAL of Massachusetts, Mr. NEAL of North Carolina, Ms. OAKAR, Mr. OBERSTAR, Mr. OBEY, Ms. PELOSI, Mr. PERKINS, Mr. ROE, Mr. SABO, Mr. SCHUMER, Mr. SHAYS, Mr. STUDDS, Mr. TALLON, Mr. TORRES, Mr. TOWNS, and Mr. WYDEN introduced the following bill; which was referred jointly to the Committees on Banking, Finance and Urban Affairs, Energy and Commerce, Education and Labor, and Veterans' Affairs

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A BILL

To amend the Stewart B. McKinney Homeless Assistance Act to extend programs providing urgently needed assistance for the homeless, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE AND TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Stewart B. McKinney Homeless Assistance Amendments Act of 1990".

(b) TABLE OF CONTENTS.—

TITLE I—GENERAL PROVISIONS

SEC. 101. BUDGET COMPLIANCE.

(a) IN GENERAL.—This Act and the amendments made by this Act may not be construed to provide for new budget authority, budget outlays, or new entitlement authority, for fiscal year 1991 or 1992 in excess of the appropriate aggregate levels established by the concurrent resolution on the budget for such year for the programs authorized by this Act and the amendments made by this Act.

(b) DEFINITIONS.—For purposes of this section, the terms "budget authority", "budget outlays", "concurrent resolution on the budget", and "entitlement authority" have the meanings given such terms in section 3 of the Congressional Budget Act of 1974 (2 U.S.C. 622).

TITLE II—INTERAGENCY COUNCIL ON THE HOMELESS

SEC. 201. TECHNICAL AMENDMENT.

Section 202(a) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11312(a)) is amended—

(1) by striking paragraph (15);

(2) by redesignating paragraphs (11), (12), (13), and (14) as paragraphs (12), (13), (14), and (15), respectively; and

(3) by inserting after paragraph (10) the following new paragraph:

"(11) The Secretary of Veterans Affairs, or the designee of the Secretary.".

SEC. 202. AUTHORIZATION OF APPROPRIATIONS.

Section 208 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11318) is amended to read as follows:

"SEC. 208. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this title $1,260,000 for fiscal year 1991 and $1,323,000 for fiscal year 1992.".

SEC. 203. EXTENSION OF INTERAGENCY COUNCIL.

Section 209 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11319) is amended by striking "October 1, 1990" and inserting "October 1, 1992".

TITLE III—FEDERAL EMERGENCY MANAGEMENT FOOD AND SHELTER PROGRAM

SEC. 301. AUTHORIZATION OF APPROPRIATIONS.

Section 322 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11352) is amended to read as follows:

"SEC. 322. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this title $140,700,000 for fiscal year 1991 and $147,735,000 for fiscal year 1992.".

TITLE IV—HOUSING ASSISTANCE

SEC. 401. EMERGENCY SHELTER GRANTS PROGRAM.

Section 417 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11377) is amended to read as follows:

"SEC. 417. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this subtitle $131,250,000 for fiscal year 1991 and $137,812,500 for fiscal year 1992.".

SEC. 402. SUPPORTIVE HOUSING DEMONSTRATION PROGRAM.

Section 428(a) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11388(a)) is amended to read as follows:

"(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this subtitle $110,250,000 for fiscal year 1991 and $115,762,500 for fiscal year 1992.".

SEC. 403. SUPPLEMENTAL ASSISTANCE FOR FACILITIES TO ASSIST THE HOMELESS.

The first sentence of section 434 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11394) is amended to read as follows: "There are authorized to be appropriated to carry out this subtitle $11,550,000 for fiscal year 1991 and $12,127,500 for fiscal year 1992.".

SEC. 404. SECTION 8 ASSISTANCE FOR SINGLE ROOM OCCUPANCY DWELLINGS.

Section 441(a) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11401(a)) is amended to read as follows:

"(a) INCREASE IN BUDGET AUTHORITY.—The budget authority available under section 5(c) of the United States Housing Act of 1937 for assistance under section 8(e)(2) of such Act is authorized to be increased by $52,500,000 on or after October 1, 1990, and by $55,125,000 on or after October 1, 1991.".

TITLE V—HEALTH CARE FOR THE HOMELESS

Subtitle A—Categorical Grants for Primary Health Services and Substance Abuse Services

SEC. 501. AUTHORIZATION OF APPROPRIATIONS.

Section 340(q)(1) of the Public Health Service Act (42 U.S.C. 256(q)(1)) is amended—

(1) by striking "$61,200,000" and all that follows through "1990, and"; and

(2) by striking the period at the end and inserting the following: "and $69,510,000 for fiscal year 1992.".

Subtitle B—Block Grant for Community Mental Health Services

SEC. 511. REQUIREMENT OF ALLOTMENT FOR STATES.

Section 521(a) of the Public Health Service Act (42 U.S.C. 290cc–21(a)) is amended by striking "1991" and inserting "1992".

SEC. 512. AUTHORIZATION OF APPROPRIATIONS.

Section 535(a) of the Public Health Service Act (42 U.S.C. 290cc–35(a)) is amended—

(1) by striking "$35,000,000 for each of the fiscal years 1989 and 1990 and"; and

(2) by striking the period at the end and inserting the following: "and $36,750,000 for fiscal year 1992.".

Subtitle C—Authorization of Appropriations for Community Demonstration Projects

SEC. 521. MENTAL HEALTH SERVICES FOR HOMELESS INDIVIDUALS WITH CHRONIC MENTAL ILLNESS.

The first sentence of section 612(a) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 290aa–3 note) is amended—

(1) by striking "$11,000,000" and all that follows through "1990, and"; and

(2) by striking the comma after "1991" and inserting the following: "and $12,075,000 for fiscal year 1992,".

SEC. 522. ALCOHOL AND DRUG ABUSE TREATMENT OF HOMELESS INDIVIDUALS.

Section 513(b) of the Public Health Service Act (42 U.S.C. 290bb–2(b)) is amended—

(1) by striking "$14,000,000" and all that follows through "1990, and"; and

(2) by striking the period at the end and inserting the following: "and $17,850,000 for fiscal year 1992.".

TITLE VI—EDUCATION, TRAINING, AND COMMUNITY SERVICES PROGRAMS

SEC. 601. ADULT EDUCATION FOR THE HOMELESS.

Section 702(c)(1) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11421(c)(1)) is amended to read as follows:

"(1) There are authorized to be appropriated $10,500,000 for fiscal year 1991 and $11,025,000 for fiscal year 1992 for the adult literacy and basic skills remediation programs authorized by this section.".

SEC. 602. EDUCATION FOR HOMELESS CHILDREN AND YOUTH.

(a) GRANTS FOR STATE ACTIVITIES.—Section 722(g)(1) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11432(g)(1)) is amended to read as follows:

"(1) There are authorized to be appropriated to carry out this section $5,250,000 for fiscal year 1991 and $5,512,000 for fiscal year 1992.".

(b) EXEMPLARY GRANTS AND DISSEMINATION OF INFORMATION.—Section 723(f) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11433(f)) is amended to read as follows:

"(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section

$2,626,000 for fiscal year 1991 and $2,756,250 for fiscal year 1992.".

SEC. 603. JOB TRAINING FOR THE HOMELESS.

(a) AUTHORIZATION OF APPROPRIATIONS.—Section 739(a)(1) of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11449(a)(1)) is amended to read as follows:

"(1) There are authorized to be appropriated to carry out this subtitle the following amounts:

"(A) $13,650,000 for fiscal year 1991, of which $2,310,000 shall be available only to carry out section 738.

"(B) $14,332,500 for fiscal year 1992, of which $2,425,500 shall be available only to carry out section 738.

(b) TERMINATION.—Section 741 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11450) is amended by striking "October 1, 1990" and inserting "October 1, 1992".

SEC. 604. EMERGENCY COMMUNITY SERVICES HOMELESS GRANT PROGRAM.

Section 754 of the Stewart B. McKinney Homeless Assistance Act (42 U.S.C. 11464) is amended to read as follows:

"SEC. 754. AUTHORIZATION OF APPROPRIATIONS.

"There are authorized to be appropriated to carry out this subtitle $50,000,000 for fiscal year 1991 and $50,000,000 for fiscal year 1992.".

TITLE VII—VETERANS PROGRAMS

SEC. 701. MEDICAL PROGRAMS.

Section 801(a) of the Stewart B. McKinney Homeless Assistance Amendments Acts of 1988 (Public Law 100–628; 102 Stat. 3257) is amended to read as follows:

"(a) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Department of Veterans Affairs $31,500,000 for fiscal year 1991 and $33,075,000 for fiscal year 1992 for the medical care of veterans by the Department. Any amount appropriated under this subsection shall be in addition to any funds appropriated pursuant to any other authorization (whether definite or indefinite) of appropriations for fiscal years 1991 and 1992.".

Mr. WAXMAN. Our witnesses this morning are individuals who have a great deal of expertise in the delivery of health care to the homeless. Professor James Wright is the author of two books on the homeless and directed the national evaluation of the foundation-funded demonstration on which the "340" program was modeled. Lynn Clothier is executive director of the Indiana Health Care Centers, Inc.; Janelle Goetcheus, M.D., is medical director of the Homeless Health Care Project, Inc.; Mary Fleming is executive vice president of the Franklin County Mental Health Board in Columbus, OH.

We are pleased to welcome each of you to our hearing this morning. Your prepared statement will be made a part of the record in full. We would like to ask each of you to limit your oral presentation to us to no more than 5 minutes. Professor Wright, let's start with you.

STATEMENT OF JAMES D. WRIGHT, PROFESSOR OF HUMAN RELATIONS, DEPARTMENT OF SOCIOLOGY, TULANE UNIVERSITY; LYNN CLOTHIER, EXECUTIVE DIRECTOR, INDIANA HEALTH CENTERS, INC.; JANELLE GOETCHEUS, MEDICAL DIRECTOR, HOMELESS HEALTH CARE PROJECT; AND MARY FLEMING, EXECUTIVE VICE PRESIDENT, FRANKLIN COUNTY (OH) MENTAL HEALTH BOARD

Mr. WRIGHT. Actually, Mr. Waxman, I think your opening remarks said pretty much everything that needs to be said this morning. Other than the programs provided through the McKinney Act, the Federal response to the problems of the homeless has been rather cautious, despite the continuing and growing severity of the problem.

Nationwide most of the efforts on behalf of the homeless comes from the private sector, principally the churches. and the remaining effort comes from State and local government, with the Feds relatively minor players at this time. The principal exception is the range of programs funded under McKinney, chief among them the health care for the homeless clinical care program now operational in about 109 cities. I am pleased to have the opportunity to speak in behalf of the reauthorization and expansion of this clinical program.

It is true, as you indicated, the homeless are no longer on the front page. It would be wrong to infer from this however that they are no longer on the streets, in the shelters and on the steam grates. Many of us have been concerned with the factors that led to the stunning increase in homelessness in the 1980's, a dwindling supply of low-income housing, employment problems, et cetera, have been identified as the principal problems, of course.

None of these factors seems to be abating as we enter the 1990's. I think most of us who work in the area of homelessness anticipate that the problem will get very much worse throughout the next decade certainly before it gets better. The number of homeless continues to increase, particularly among groups that society has traditionally obligated itself to protect—children, women, families, the physically infirm.

This is not to minimize the good that has been done but to underscore that much remains to be done. It has been said with considerable justification the homeless probably harbor the largest pool of untreated disease in the United States today. The research I and others have undertaken over the last decade has shown beyond a reasonable doubt that homeless people suffer from an extremely wide range of severe, sometimes unique health problems. More perhaps to the point, we have also confirmed that homeless people rarely receive health care attention in the absence of specific targeted primary care programs such as health care for the homeless.

Whatever disease one cares to look at, the rate of occurrence is higher among homeless than domiciled people, often by stunningly large factors. The rate of tuberculosis infection, for example, exceeds the rate of infection of population as a whole by a factor of 100 and the same is true of HIV infection as well. Homelessness makes people ill. In the extreme it proves to be a fatal condition.

Studies of mortality among the homeless suggest that they die about 20 years earlier than would be normal given the life expectancy for the population as a whole. Access is problematic for a number of reasons. First, they are the poorest of the poor, almost always to be found among the 37 million Americans who lack health insurance of any sort. Absent money and health care insurance, most of the health care delivery systems are effectively beyond their reach. More perhaps to the point homeless people are often considered undesirable patients. They are often disheveled, alcohol impaired, substance abusive, mentally ill. They are the frequent victims of the "Gomer" syndrome—get out of my emergency room. It is therefore not sufficient to just provide the homeless with existing health care facilities, like expanded coverage of the Medicaid system. It is also necessary to provide a delivery system that welcomes them as patients.

I think this is the principal achievement of the 109 McKinney programs at this point. We have created clinics that welcome the homeless as clients and we have created clinics where homeless people feel comfortable going. I cannot stress too highly the importance of this accomplishment. I think dismantling the system now or failing to allow it to expand and grow to its natural course would be little short of cruel. I will not review the accomplishments of the program over the first couple of years.

Certainly the number of clients being seen day to day in these clinics testifies to the great need to keep these clinics open and expand the resources available to them so they can expand their reach even further to the target population.

At present there are something like 115 cities around the Nation that do not participate in the McKinney program because of inadequate funds. There are some 22 programs in that bizarre state of Federal limbo known as "approved but unfunded". The legislation currently under consideration by this committee would fund these 22 programs. It would refund the 109 existing programs and perhaps allow some extension of these critical services to other urban and rural areas where unmet needs are currently so high.

It is not likely in my view that even a doubling of the funds available through McKinney would be adequate to meet the national need. So I regard the expansion of resources called for in the

pending legislation as best a minimum, but certainly an essential step.

This is not a cheap program. Current expenditures run about $50 million per year. In fiscal year 1991, anticipated expenditures are about $36 million. The pending legislation would increase that to $90 million and also stabilize program funding over 3 years.

I think it is useful to ask why we should be spending this money providing health services to homeless people. First, the HCH experience to date confirms that it is money well spent. The program model has been shown to work. The numbers of clients being seen, if nothing else, indicates the degree of need.

Second, the program has already run through 2 successful years. I think in that respect it has earned the enhanced resources and increased stability that this legislation would provide. These are not the only good reasons to move forward. I think of all the reasons the most important is that our dignity as a just and compassionate Nation demands a generous and long-term congressional commitment to improving the lives and well-being of the most destitute and unfortunate among us.

The legislation now being considered would be a modest but important step in the right direction.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Wright.

[The prepared statement of Mr. Wright follows:]

PREPARED STATEMENT OF DR. JAMES D. WRIGHT, PROFESSOR OF HUMAN RELATIONS, DEPARTMENT OF SOCIOLOGY, TULANE UNIVERSITY

The federal policy response to the problem of homelessness in our nation has been cautious and guarded to this point. Nationwide, nearly three-quarters of the total effort in behalf of the homeless comes from the private sector, principally the churches. Most of the remaining effort is state and local. Although nearly all observers would agree that homelessness is a national problem, and therefore requires national programs and solutions, the federal response to the issue has so far bean rather timid.

The principal exception to this generalization is the Stewart B. McKinney Homeless Assistance Act, which provides federal funds for a range of interventions that aid the homeless, one of the most important of which in the National Health Care for the Homeless [HCH] clinic system now operational in 109 localities around the country. Legislation currently under consideration by the Congress would reauthorize the HCH system, add funds to enable the expansion of HCH to additional localities, and stabilize program funding for the next three fiscal years. All of these are necessary and commendable measures, and I am thankful for the opportunity to speak in their behalf.

The decade of the 1980s witnessed a steady worsening of the homelessness problem and a rapid increase in the size of the homeless population. A perpetually dwindling supply of low income housing, coupled with deteriorating welfare benefits, an inflation-ravaged minimum wage (recently increased for the first time since 1981), an upwardly drifting poverty rate, the steady loss of entry-level industrial jobs, and a host of other social, economic, and political factors have conspired to create a large and apparently growing class of homeless citizens who lack access to the most basic necessities of existence. They eat what the soup lines give them to eat, or scavenge food from street sources; they sleep in the overnight shelters for the homeless, or in our parks and streets; lacking both money and health insurance, they receive attention for their many severe health problems through the HCH clinic system, or they do without. It maddens me that we allow this madness to continue.

As we enter the decade of the 1990s, there are few if any hopeful trends on the horizon. All the forces that have created this problem remain in place. Most of the programs now addressed to the homeless are focussed on amelioration, not on basic solutions. Our goals to this point have been to make the lives of homeless people

somewhat more comfortable and less degrading, not to reduce or eliminate the number of people who must live uncomfortable and degrading lives.

Homelessness has become somewhat passe as a political issue and as a topic for media and public attention, but it would be wrong to infer from our declining attentiveness that the problem itself has abated. To the contrary, the number of the homeless continues to grow: among single men and women, to be sure, but also among families and children, in urban and rural areas alike, throughout the nation. This is not to gainsay the good that McKinney and other programs have accomplished, only to underscore that the problem has not been solved, not by any means, and that a great deal remains to be done.

The research undertaken in the 1980s by me and many others showed beyond serious question that homeless people suffer from a wide range of severe and sometimes unique health problems. More, perhaps, to the point, this research also showed that homeless people rarely receive adequate health care attention in the absence of specific targeted primary care programs such as those embodied in HCH. Comparisons of disease prevalence between the homeless and comparable samples of domiciled persons show wide disparities for nearly every disorder. Whatever physical disorder one examines, in short, the homeless are more likely to suffer from it.

To illustrate, the rates of tuberculosis and HIV infection among the homeless exceed those in the general population by a factor of roughly one hundred. There is more hypertension and untreated diabetes among the homeless than among the domiciled, more trauma by far, more lice infestations and skin disorders—in short, more of nearly everything. And this is true of all subgroups among the homeless: homeless men are sicker than domiciled men, homeless women sicker than domiciled women, homeless children much sicker than domiciled children. Among the many good reasons to do something about the problem of homelessness is that homelessness makes people ill. In fact, it is often a fatal condition; various studies suggest that the life expectancy of the homeless is about twenty years less than the life expectancy of the population as a whole.

Access to conventional health care delivery systems is problematic for the homeless on a number of counts. First, of course, they are among the poorest of the poor and are almost always to be found among the estimated 37 million or so Americans who lack health insurance of any sort. Absent money and an adequate fee source, most of the health care delivery system is beyond their reach. Moreover, homeless patients are considered "undesirable" in many health care facilities. They are often disheveled and debilitated, frequently drug or alcohol abusive, and many (perhaps a third) are mentally ill. They are the frequent victims of what has been called the GOMER syndrome: Get Out of My Emergency Room.

It in therefore not normally sufficient just to provide the homeless with access to the existing health care system; it is also necessary to provide a delivery system that will have them as patients. To have done this is a principal achievement of the McKinney-funded HCH system. McKinney has created 109 health care clinics around the nation that welcome homeless people and—equally important—where homeless people are comfortable going. The importance of this accomplishment cannot be stressed too highly. To dismantle this system now, a mere two years after its inception, would be little short of cruel.

The performance of the McKinney-funded HCH clinic system in its first two years is certainly commendable. In the first year, roughly 231,000 homeless persons received health and related social services through this clinic system; in the second year, the client load grew to nearly 350,000. Thus, the system is a demonstrably workable strategy for bringing homeless people into a professional program of primary health care. The shear number of clients being seen is ample testament to the need for this system, but the ultimate success can only be gauged in the reduction of pain and suffering among those who have availed themselves of HCH services. No serious observer would doubt that the successes, measured in these terms, have been considerable.

Still, much remains to be done. The homeless clients now being seen in the HCH clinics, it appears, do not represent much more than a third of the total homeless populations of the 109 localities where theme clinics are currently sited. The existing programs need additional resources to extend their reach further into the target population. There are, moreover, 22 new HCH clinical programs that have been approved for funding but remain unfunded. Resources need to be made available at once to bring these 22 approved new programs on line. There are, in addition, 115 metropolitan areas in the nation that are not currently served at all by the HCH program and that would remain unserved even if the 22 approved new projects were funded. Finally, although the rural homeless comprise, by some estimates, a quarter of the total national homeless population, very few rural homeless receive services

through HCH; resources have simply not been adequate to extend the HCH system into the rural areas, In short, even a doubling of the funds available to the program would probably not meet the total national need. The expansion of program resources called for in the pending legislation is, at best, a minimum although essential first step.

Homeless people rarely have just one health problem that requires attention. The difficulties and expense of providing them with adequate health care are increased by the high rates of co-occurring disorders such as psychiatric impairment and substance abuse. Alcohol and substance abuse disorders are the most frequent problems encountered among HCH clients; among homeless men, the rate of alcohol abuse alone is reliably estimated to exceed 50 percent. Sadly, funding shortfalls below the authorized levels have prevented the HCH clinics from providing appropriate types and levels of substance abuse treatment for homeless people. Much the same can be said for appropriate types and levels of psychiatric care. These are areas where the need for enhanced program resources is especially critical and obvious. (Only eight of the 50 states are known to have substance abuse services in place that are specifically targeted to homeless people.)

Funding for the HCH system has so far proceeded on a year-to-year basis. Total operating costs of the 109 projects for the 1990 calendar year amount to about $50 million. The 1991 calendar year expenditures under the existing program are estimated to run to about $63 million, due to the fiscal year 1991 advance funding utilized by Congress last year to ensure 12-month renewals for the existing projects. The year-to-year funding pattern has created unnecessary organizational uncertainty throughout the system and has required the expenditure of a great deal of effort on the annual reapplication process, effort that might otherwise have gone into service delivery. I urge support for currently pending legislation that would increase total program resources to about $90 million per year, thus allowing for some of the necessary expansion of the system mentioned above, and that would stabilize the funding authorization for a three year period.

Why should we spend this kind of money providing health services to homeless people. First, the HCH experience to date confirms that it is money well-spent. The program model has been shown to work. Secondly, the need for the program has not diminished; if anything, the need has grown. Two successful years have earned the HCH system the enhanced resources and increased stability that this legislation would provide. But these are not the only good reasons to move forward at this time. Our dignity as a just and compassionate nation demands a generous and long-term Congressional commitment to improving the lives and well-being of the most destitute and unfortunate among us. The legislation under consideration today is a modest but important stop in this direction.

Thank you.

Mr. WAXMAN. Ms. Clothier.

STATEMENT OF LYNN CLOTHIER

Ms. CLOTHIER. Good morning, Mr. Chairman. I would like to correct the record. Although my administrative office is in Indianapolis, the homeless program I am operating is in South Bend, IN. I am with the Indiana Health Centers. We operate 13 health centers around the State of Indiana, including a "340" grantee.

We began with the Stewart B. McKinney program at the inception of its funding and immediately became extremely surprised about the number of homeless people we are seeing.

It was totally unexpected. I am here on behalf of the people we are serving in Indiana and the over 350,000 homeless who are currently receiving health care to urge you to reauthorize this needed program. I recommend we increase the authorization level to $90 million.

I have five very specific reasons that I believe we need to do that. First, I believe very, very strongly, as do many people in this country, that we have not yet realized the full scope of this problem. I think the 350,000 that are being served represents the tip of the pyramid. When we began in February 1988, everybody's best guess

was that there were approximately 500 to 1,000 homeless persons in South Bend.

Within 4 months we had seen 800 people. As I speak to you now, we are denying health care to 12 to 15 persons per week at our specific homeless health center programs in the shelters due to current lack of resources. Several other groups around believe very strongly that this is not only a large existing problem that we don't know the total scope of yet, but that it is also growing. I would point out to you that we in Indiana can currently shelter only 22 percent of the homeless persons that we are seeing.

The second reason I believe we need to reauthorize this program is that obviously the problems of homelessness in America took many years to develop and cannot be solved overnight. It will take many years of stable programming to resolve them. Our first 2 years operating this program have been a roller coaster. We are spending a great number of hours and resources responding to the partial funding, dealing with multiple notices of grant awards within the same fiscal year. It is very difficult under that circumstance to package something and go far with it.

I believe a 3-year authorization would allow the McKinney programs to do a little more long range planning and begin to stabilize themselves. We also need to reauthorize this program because impacting on this crisis is going to take resources in direct proportion to the size of the problem.

Not only are we dealing with roller coaster appropriations and uncertainty about the future of the program, but we are dealing with resources that are totally inadequate for what we are trying to do. The McKinney programs are estimated to be serving only 35 percent of the American homeless.

I believe we have done an incredible job of picking up this program and responding to it in a very immediate manner. For example, my program in South Bend received a notice of grant award in December. By the following February 4 we opened in two permanent locations for expanded services to the homeless.

That experience is replicated nationwide. The health centers in the Robert Wood Johnson program on which this model is based responded immediately. We have seen staggering numbers of people. I do believe it is just the tip of the pyramid. I do believe we are able to address only the tips of problems we are encountering simply by not having the resources needed.

I think we ought to reauthorize this program because with current resources we are not able to provide a full service package. The service needs are extremely diverse, extremely long standing and they will take a lot of resources to respond to. With the reduction in funding in the last couple of years I believe that we are seeing programs start to eliminate some services in favor of others.

It is extremely difficult to be put in that situation, Mr. Chairman. How do we make the decision to take care of a broken arm versus a case of alcoholism. How do we make the decision to choose between a gangrenous limb and a mental health program. If we are going to impact, we are simply going to have to be able to provide the broadest range of services possible.

Arriving in Washington yesterday evening, I shared a plane ride with an Army Lt. Colonel who was returning from Indiana. As we

spoke about why we were coming to Washington last night and I shared with him my mission here, he was staggered to find that we do not appropriate for health care for the homeless program in America funding equally even to the cost of one B–2 bomber. I didn't know what they cost but he did.

The final reason I believe we need to reauthorize this program is because we have a way to do it, we have a way to impact on this program. Frequently I believe in America we identify problems that are just staggering and we don't know how to address them. We don't know what would be effective and we don't know how to eliminate human suffering.

With this program we have a model. We are building on the community health centers as well as the Robert Wood Johnson program. So we do know how to fix this. I urge you to look at the authorizing levels and make those sufficient for us to address this problem. I would reiterate, with the fiscal year 1992 authorization level we simply do need $90 million. I think that is a modest amount of money. I understand it is not even two B–2 bombers. This is not a problem that is going to go away by itself. It has to be addressed in an adequate and stable manner. The homeless people in America do not want to be homeless. I would urge you to help us turn the national tragedy of homelessness into a group of contributing citizens.

Thank you.

Mr. WAXMAN. Thank you very much for your testimony, Ms. Clothier.

[The prepared statement of Ms. Clothier follows:]

PREPARED STATEMENT OF LYNN CLOTHIER, EXECUTIVE DIRECTOR, INDIANA HEALTH CENTERS, INC.

Mr. Chairman and Members of the Subcommittee, my name is Lynn Clothier. I am Executive Director of Indiana Health Centers, which is a private, nonprofit consumer governed corporation in the State of Indiana. We operate health and health related programs throughout the State of Indiana comprising 13 service locations. Our programs include community and migrant health centers as well as homeless health centers. While we have served thousands of uninsured indigent and migrant families over the last 14 years, during the past two years, since the inception of our funding under the McKinney Act's Health Care for the Homeless Program, our centers have served 1,395 homeless persons in South Bend, Indiana, 16 percent of whom are children, 19 and under, and another 65 percent are females of child bearing age. Our health teams provide primary health care to persons in three permanent locations in South Bend, Indiana. If we have been surprised by anything we have learned during this time period, it is that the numbers of homeless people and their need for health care are much greater than we had anticipated, and the full extent of homelessness in our community is yet to be realized.

On behalf of the patients we serve in Indiana, who literally have no other source for primary health care and the 352,075 homeless patients served by the 109 Health Care for the Homeless projects annually we urge you to reauthorize the Stewart B. McKinney Act health care programs, particularly the Health Care for the Homeless Program, for at least three years at higher levels to meet a greater proportion of unmet need. Specifically, we recommend an increase in the fiscal year 1992 authorization level to $90 million.

The Health Care for the Homeless Program needs to be reauthorized at increased levels for five reasons:

(1) We have not yet realized the true scope of this problem. Unfortunately, identified homelessness is still increasing, and our efforts to expand affordable housing, jobs, and health care coverage to the remaining uninsured have to date been too meager to stem this tide. The U.S. Conference of Mayors 1989 report documents a 25 percent increase in the demand for emergency shelter in the largest cities. In South Bend, Indiana we have only 312 shelter beds for the 1,395 homeless we have

identified thus far. That means that only 22 percent of the homeless of South Bend can be sheltered on any given night.

(2) The problems of homelessness in America took years to develop and will take years of stable programming to resolve. Given the trenchant nature of homelessness, slow progress of longer term solutions, and the growing numbers of homeless families urgent relief efforts will continue to be needed at least through fiscal year 1993, if not longer. The Health Care for the Homeless Program has experienced complicated rollercoaster appropriations, and it has been forced for two years to provide multiple partial-year awards to its grantees—leaving the projects in a continued, highly unstable situation. This year an emergency fiscal year 1990 supplemental appropriation was required to stave off the defunding of some 17 projects, and even then some projects had to cut back services. This program has had two authorizations in four years. A three year reauthorization would help stabilize the program, aid in staff recruitment and retention, and assist with strengthening subcontractor relations.

(3)Impacting on the homeless crisis will take the resources in direct proportion to the size of the problem. The current 109 projects meet only 15 percent of the need for primary health care services among the homeless nationally. The 109 projects served 352,075 homeless persons in 1989. While this is an outstanding accomplishment, it represents only 35 percent of the 1,012,430 homeless persons reported by these communities annually. Furthermore, there are 115 metropolitan cities not served by Health Care for the Homeless projects which participate in the Emergency Shelter Grant Program, a companion McKinney program. There are twenty-two new HHS approved-but-unfunded health care projects with requests totaling $6 million awaiting funding, some of them in largely rural states, like Maine, North Dakota, and Alaska, that did not receive funding in the first competitive cycle, due to lack of resources. Finally, rural communities are estimated by some studies to comprise between 16 and 25 percent of the homeless population, but too few rural homeless are served by the current program due to funding limitations. Clearly, the current program, while highly productive, meets only a modest percentage of the need for primary health care services among our most indigent population, both urban and rural.

(4) The limited resources currently available are not providing adequately for the full service package necessary to impact the problem. The service needs of our homeless patients cannot be met within the framework of the existing authorization ceilings. The Health Care for the Homeless Program by design is a multidisciplinary program, required to provide primary health care, substance abuse, mental health and entitlement assistance services. Supportive social services also are absolutely necessary in meeting the health care needs of the homeless. Unfortunately, funding shortfalls below authorization levels have minimized the amount and types of substance abuse services that could be provided for our homeless patients despite the fact that the single largest number of encounters by diagnosis for patients 15 and over nationally was for alcohol and substance abuse. In the most recent round of funding shortfalls, a number of projects were forced to discontinue substance abuse treatment subcontracts. Since substance abuse among the homeless is often chronic and entrenched, more treatment episodes can be expected, greater intensity of treatment is required, and treatment modalities more appropriate to the homeless need to be developed in many communities. It should be noted that given the needs of this population, any simplistic cost per user ceilings militate against program effectiveness and we hope that BHCDA will reconsider the cost standards it applied during the last year's funding cycle to the detriment of some sound projects. Additionally, treatment of homeless AIDS patients is straining Health Care for the Homeless budgets in some communities. Finally, the homeless have very limited access to public or private health insurance. During the first year of Health Care for the Homeless operation, nationally 56 percent of the homeless for whom data could be supplied had access to no medical insurance or cash assistance. Only about one quarter of the patients appeared to be eligible for medical insurance, including Medicaid. Extreme indigency and homelessness does not provide presumptive eligibility for Medicaid because Medicaid is primarily a dependent-based program. In summary, the Health Care for the Homeless program is seriously underfunded given the extent of illness in this population, the lack of access to medical insurance, and the need for multidisciplinary health services.

(5) Unlike some national problems, we have a proven national model to address the homeless health care problem. Building on the highly successful community and migrant health center model and the experience from the Robert Wood Johnson/PEW Memorial Trust demonstration project, the Health Care for the Homeless Program has proven to be an unusually productive program in a short period of time.

despite its considerable funding uncertainties. In its first full year of operation, the program served 231,068 homeless persons through 783,336 encounters, exceeding its goal by 15 percent. An average of 3.4 patient encounters was provided. Thirty percent of the patients whose family status was known were members of homeless families, and over 21 percent of the homeless patients were children aged 0 to 19. In 1989, the projects served 352,075 homeless patients, (an increase of 52 percent over 1988), through 1,356,662 patient encounters (an increase of 73 percent). Consistent with the integrated health care model of this program, 44 percent of the service encounters were for primary health care, 25 percent were for case management/social services, 15 percent were for substance abuse services, 8 percent were for mental health services, and the balance were for dental, educational, and other support services. The program is operated by a mix of providers—approximately half are community health centers while the balance are public health departments, other nonprofit clinics, and hospital outpatient programs. BHCDA has facilitated training, development of special clinical protocols, and other communication and capacity-building activities for the projects for two years through a grant to our National Association in conjunction with St. Vincent's Hospital in New York. This investment in training has paid off in a well-informed national provider network which shares information on problems and successful approaches. The programs coordinate extensively at the local level with other McKinney Act Programs and community resources. Finally, the programs raise a 33 percent nonfederal match to their federal funds, a not insignificant amount, especially in smaller communities. The Federal Interagency Council on the Homeless has indicated on several occasions that the FEMA and Health Care for the Homeless Programs are two of the most effective McKinney Act programs based on feedback from statewide "town meetings" held across the country.

In closing, we ask your support for an extension of the Section 340 authority through at least fiscal year 1993, and an increase in the fiscal year 1992 authorization level to $90 million, an increase we believe is modest in relation to the current and growing need. This is not a problem that will go away by itself, it must be addressed in an adequate and stable manner if we are to revert America's homeless persons from a national tragedy that drains our resources to a national treasure of contributing citizens.

Thank you.

Mr. WAXMAN. We will hear now from Dr. Goetcheus.

STATEMENT OF JANELLE GOETCHEUS

Ms. GOETCHEUS. Thank you, Mr. Chairman.

I am a physician and medical director of the Health Care for the Homeless Project here in Washington. Along with four other physicians and their families, I live at a facility called Christ House where 34 sick, homeless people live with us during the time of their recovery. I am here today to urge you to extend the authorization for the Homeless Health Care program and to increase the authorization level.

For the past 14 years, my primary work as a physician has been with and among the homeless of Washington. What I have learned in these 14 years is how very, very physically ill are many of those who are homeless. During the past year in Washington, we saw 25,000 patient visits from 8,400 patients, plus another 6,000 outreach encounters. These visits occurred in health services in the shelters, on the streets, and under bridges. The Health Care for the Homeless Project has placed health services in 11 shelters which range in capacity from 100 persons up to 1,400 persons. Additionally, an outreach medical van carrying a medical team travels nightly to the parks and grates around the Federal buildings. We have an outreach van that goes down each night among these buildings traveling with a medical team to see persons. But it was not until we began actually going into the shelters that we began to see the sickest patients.

Here in Washington on the initial day that the Health Care for the Homeless Project opened, the first patient I saw was a 46-year-old gentleman with tuberculosis. He had been hospitalized and released to a shelter. He was malnourished, very anemic, short of breath, and had large cavities in his lungs from the tuberculosis. He was still too weak to walk the 11 blocks to eat at a soup kitchen—so his condition was deteriorating.

Each day as a physician, I see persons with complications of illnesses that just never should have occurred. We see diabetics who are trying to manage their diabetes on the street. Trying to find a diabetic diet in a soup kitchen is almost impossible. I have seen young men, 40-year-old men who had strokes. If you walk with me through the shelter you will see those people who have had paralysis on one side of their body and who have difficulty speaking.

These are people who have gone to emergency rooms to get prescriptions that they never could have afforded for blood pressure. I see terminal cancer patients going back and forth between the shelter and the hospital, getting radiation and chemotherapy. The American Cancer Society held hearings around the United States this year regarding cancer mortality rates in the uninsured.

I had a young man who came in one morning extremely malnourished and having difficulty eating. He carried a note from an emergency room. It said, "Eat more bran flakes for constipation."

He had terminal cancer and died shortly thereafter. We are seeing people walking the street who are confused and demented. There are many mentally ill languishing on the streets of Washington and throughout the Nation. These persons have been discharged from psychiatric hospitals but have not been given adequate community support. When you walk the streets throughout the Nation, these persons, who are often very psychotic, are very visible and numerous. To the left of the Washington Monument, on a park bench sits a gentleman, a college graduate, who is very psychotic. He sits there 365 days of the year.

One of the most distressing problems is that of the growing number of "dually diagnosed" patients—that is, those who are both psychotic and addicted to various street drugs.

A growing number of homeless persons we are now seeing are addicted to drugs and alcohol. They come asking for help, but few inpatient programs are available and the waiting lists are long. The morning I wrote this testimony I sat with a gentleman who was a Vietnam veteran who came asking for help. He was crying as he said, "I'm dying and I want to get off heroin." He had walked to a methadone treatment center and was told he could not be seen for 3 weeks. I called thinking I could get an earlier appointment. I had not given the gentleman's name but I told them he was an HIV positive and was using heroin and I was concerned. Again, it was 10 days before he could go for methadone. So he left the health service possibly to do more heroin and possibly to spread the HIV virus.

In the cold weather here in Washington we see people losing fingers and toes every day. One of our patients this year lost both legs. The heat grates on which many huddle often cause burns—third degree burns require skin grafts. Every winter patients of ours freeze to death. Regularly, pictures of unidentified bodies that

are in the morgue are circulated among the shelters to help in the identification.

Every year I see 50-year-old men with bodies of 70-year-old men. These persons have gone without primary health care most of their lives. They have done heavy day labor for which no health benefits were ever provided, and now at age 50 are unable to continue this heavy labor. Their health has deteriorated to that of what one would expect of a 70-year-old man with a chronic illness. Being unable to pay rent, they are chronically ill and they are now stuck in shelters.

I think my heart aches most for the homeless children who suffer all the emotional and physical ravages that poverty brings.

The last few months for me have been most difficult in terms of the HIV patients we have seen. The last several months have been overwhelming for us as physicians. In the shelter health services, we are following over 200 persons with HIV infection in various stages. In the past 9 months, we have seen the number of HIV patient visits increase from 136 per quarter to 219 per quarter. We estimate that we will see approximately 250 new HIV cases in the next year. Persons with HIV who come to us are often very ill and weak from marked weight loss, fever, shortness of breath, and daily diarrhea. They have great difficulty surviving the shelters, often having been discharged from the hospitals while still recovering from pneumonia and meningitis. One man with HIV infection was recently discharged from the hospital in a wheelchair because he was too weak to walk.

With an increase in HIV infections comes more and more tuberculosis—tuberculosis of the lung, the brain, and now we are seeing tuberculosis in the glands of the neck. I had seen this in Africa but for the first time now we are seeing TB of the lymph nodes in the neck. Persons with AIDS often are afraid of staying in the shelters for fear of violence and of exposure to infections such as tuberculosis. Thus, in the streets, under the bridges, in bus stations and train stations, they attempt to survive. I tell shelter providers that the shelters will be full of dying HIV patients and the streets will be as in third world countries where bodies of the dying are picked up from the streets.

As a physician I have come to know homelessness as a fatal illness. Each year, we have a service for remembering those homeless whom we have known and who have died during the year. This year, 53 names were read, the average age of the deceased being 56. In the last 6 weeks, I have helped plan funerals for six homeless persons and it is anticipated that one more will die soon.

Before the Health Care for the Homeless Project began, the primary access to medical care for these homeless persons was through the emergency room—going from crisis to crisis. We recently asked 45 of our health service patients where they would go if the health service were to close. Forty-three of the 45 said they would go to the emergency room. Last year the project had 25,000 patient visits from 8,400 patients, with an additional 6,000 outreach encounters. That is an increase of 31 percent over total encounters in 1988. These numbers reflect that homeless persons not only come for primary care, but return for ongoing care. In addition, over 300 volunteer physicians have provided specialty consultations

to the homeless here in Washington. Seventy-five percent of the homeless patients kept their appointments.

The Health Care for the Homeless Project has demonstrated that it is possible to access the homeless for health care, but more resources are needed. The number of patients continues to grow and the severity of illnesses progresses. In Washington, we are not even beginning to meet the need. At the larger shelter of 1,400 we begin signing patients up at 8:30 a.m. By 9:30, the list closes and the remainder of the patients are told to go to the emergency rooms. We will often see 40 or more patients in a half day. Many other shelters where we cannot provide health care go unserviced.

If the homeless are to survive, it is essential that they have access to health care. This is our humane duty, but health care for the homeless also keeps these persons out of expensive emergency rooms, hospitalizations and long term placement.

The Health Care for the Homeless Program has also shown that it enables persons to leave the state of homelessness and move into alternative settings. Christ House, a respite care facility where the sick homeless stay, has cared for over 1,500 patients. Of those, 67 percent were placed into alternative housing settings.

At Christ House for myself and the other physicians, it has been a privilege to work and live with those who are homeless. Many of the homeless are often very ill when they come to us. But during this crisis in their life, and during the recovery process, they sometimes discover their own giftedness, their own talents, and with support, begin to move into new settings. We regularly see persons who move into transitional housing, into jobs and then into permanent housing. One of these persons now works with us as a medical assistant in the project.

The McKinney money for the homeless health care program has enabled care for many such homeless persons who otherwise would receive no care—and the money has been very effectively used. However, the amount has been far too little to meet the growing need. I urge the committee to consider increasing the authorized level in order that care may be provided for those who suffer greatly.

A play given on the grounds of the Capitol just before the McKinney legislation was passed contained a line which said: "To be gravely ill and seriously ill is devastating. To be gravely ill and seriously impaired and homeless is beyond the realm of imagination."

Thank you.

Mr. WAXMAN. Thank you.

[The prepared statement of Ms. Goetcheus follows:]

PREPARED STATEMENT OF JANELLE GOETCHEUS, MEDICAL DIRECTOR, HOMELESS HEALTH CARE PROJECT

My name is Janelle Goetcheus. I am a physician and Medical Director of Washington, D.C.'s Health Care for the Homeless Project. Along with four (4) other physicians and their families, I live at Christ House, a respite care facility where thirty-four (34) sick, homeless persons stay during their time of recovery. I am here today to urge you to extend the authorization for the Homeless Health Care program and to increase the authorization level.

For the past fourteen (14) years, my primary work as a physician has been with and among the homeless of Washington. What I have learned in these fourteen (14)

years is how very, very physically ill are many of those who are homeless. During the past year, the Project had 25,000 patient visits from 8,400 patients (plus another 6,000 outreach encounters). These visits occurred in health services in the shelter, on the streets, and under bridges, The Health Care for the Homeless Project has placed health services in eleven (11) shelters which range in capacity from one hundred (100) persons up to fourteen hundred (1,400) persons. Additionally, an outreach medical van carrying a medical team travels nightly to the parks and grates around the Federal buildings.

It was not until we began to provide health care directly in the shelters that I began to see the very sickest of persons. Here in Washington on the initial day that the Health Care for the Homeless Project opened, the first patient was a forty-six (46) year old gentleman with tuberculosis. He had been hospitalized and released to a shelter. He was malnourished, very anemic, short of breath, and had large cavities in his lungs from the tuberculosis. He was still too weak to walk the eleven blocks to eat at a soup kitchen—so his condition was deteriorating.

Each day as a physician, I see persons come with complications of illnesses that just never should have occurred.

Regularly I see young men who have had strokes simply from not having had their high blood pressure treated or not having been able to afford their high blood pressure medications. Walking through the shelters, I see men who are now paralyzed on one side of their body and have difficulty talking. When I was on the Medical Outreach Van recently, we stopped at a grate where I found a man whose blood pressure was dangerously high (190/135). In his pocket, he had a prescription from an emergency room for blood pressure medication. He had taken this to a pharmacy but could not afford the fifty-four ($54.00) dollars to have it filled.

Daily I see diabetic homeless patients who are trying to manage their diabetes while on the street. Trying to obtain a diabetic diet in a soup kitchen is almost impossible. Also carrying syringes with them, they are in constant danger of being robbed by addicts who want the needles for use or resale to other addicts. Because they don't get regular medical care, amputations are not uncommon among homeless diabetics.

Regularly we find homeless persons with terminal cancer trying to survive in the shelters. They live between the shelter and the hospital where they receive radiation and chemotherapy. Recently, I was asked by the staff of a shelter to see a man who was too sick to get out of bed. He had obviously lost a lot of weight. After examining him closely, I could tell that he had cancer and the cancer had spread throughout his body. Another man who was brought into the shelter health service recently, just having been discharged from an emergency room, carried with him a discharge note written by a physician that said, "Eat more bran flakes for your constipation." This man had terminal cancer and was to die shortly thereafter.

More and more elderly persons are trying to survive in the streets of Washington. Often these persons are very confused or demented and totally unable to care for themselves. A nurse from one of our health services in a shelter called me recently concerning an elderly, demented gentleman who had been transported by taxi from a local hospital with instructions to leave him at the shelter. The gentleman was incontinent of urine and his clothes were soaked. The nurse accompanied the gentleman back to the hospital; and when they walked into the emergency room, he was immediately recognized as, for the prior two days, he had been staying in that emergency room. Someone from the hospital staff came out and told our nurse that she might as well take him back to the shelter for, if she did not, he would simply sit in the emergency room again and eventually be taken to another shelter.

Languishing on the streets of Washington and throughout the nation are those who are mentally ill. These persons have been discharged from psychiatric hospitals but have not been given adequate community support. When you walk the streets throughout the nation, these persons, who are often very psychotic, are very visible and numerous. To the left of the Washington Monument, on a park bench sits a gentleman, a college graduate, who is very psychotic. He sits there 365 days of the year.

One of the most distressing problems is that of the growing number of "dually diagnosed" patients—that is, those who are both psychotic and addicted to various street drugs.

A growing number of homeless persons we are now seeing are addicted to drugs and alcohol. They come asking for help, but few inpatient programs are available and the waiting lists are long. This morning, a former Viet Nam veteran came asking for help. He was crying as he said, "I'm dying and I want to get off heroin." He had walked to a methadone treatment center and was told he could not be seen for three (3) weeks. I called thinking I could get an earlier appointment. I was told

the earliest appointment would be in ten (10) days. He had tried to stop on his own but was becoming sick from withdrawal. He left the health service possibly to go out to use heroin—and to spread the HIV virus.

Each winter, because of frostbite, persons lose fingers and toes. One of our patients this year lost both legs. The heat grates on which many huddle often cause burns—third degree burns require skin grafts. Every winter patients of ours freeze to death. Regularly, pictures of unidentified bodies that are in the morgue are circulated among the shelters to help in the identification.

These persons have gone without primary health care most of their lives. They have done heavy day labor for which no health benefits were ever provided, and now at age fifty (50) are unable to continue this heavy labor. Their health has deteriorated to that of what one expects of a seventy (70) year old man with a chronic illness. Being unable to pay rent, they are chronically now stuck in shelters.

Children suffer all the emotional and physical ravages that poverty brings. At least forty percent (40 percent) are behind in immunizations, at least one year of school behind where they should be, and often emotionally damaged for life. With crowded conditions, these children are subject to acquiring infections such as pneumonias and meningitis. It is not uncommon to find that these children (including newborn infants) have suffered for days with serious medical illnesses while crack-addicted mothers have neglected them. These mothers often turn to prostitution to support their habits, putting them at very high risk for HIV. The fastest growing rate of HIV infection in our population is among these homeless women, especially those whose primary sexual partner is an IV drug user.

The last several months have been overwhelming ones for us as physicians. In the shelter health services, we are following over two hundred (200) persons with HIV infection in various stages. In the past nine (9) months, we have seen the number of HIV patient visits increase from 136 per quarter to 219 per quarter. We estimate that we will see approximately 250 new HIV cases in the next year. Persons with HIV who come to us are often very ill and weak from marked weight loss, fever, shortness of breath, and daily diarrhea. They have great difficulty surviving in the shelters, often having been discharged from the hospitals while still recovering from pneumonia and meningitis. One man with HIV infection was recently discharged from the hospital in a wheelchair because he was too weak to walk. With an increase in HIV infections comes more and more tuberculosis—tuberculosis of the lung, the brain, and now we are seeing tuberculosis in the glands of the neck. Persons with AIDS often are afraid of staying in the shelters for fear of violence and of exposure to infections such as tuberculosis. Thus, in the streets, under the bridges, in bus stations and train stations, they attempt to survive. I tell shelter providers that the shelters will be full of dying HIV patients and the streets will be as in third world countries where bodies of the dying are picked up from the streets.

As a physician I have come to know homelessness as a fatal illness. Each year, we have a service for remembering those homeless whom we have known and who have died during the year. This year, fifty-three (53) names were read, the average age of the deceased being fifty-six (56). In the last six (6) weeks, I have helped plan funerals for six (6) homeless persons and it is anticipated that one (1) more will die soon.

Before Health Care for the Homeless Project began, the primary access to medical care for these homeless persons was through the emergency room—going from crisis to crisis. We recently asked forty-five (45) of our health service patients where they would go if the health service were to close. Forty-three (43) of forty-five (45) said they would go to the emergency room. Last year the Project had 25,000 patient visits from 8,400 patients (with an additional 6,000 outreach encounters). That is an increase of thirty-one (31 percent) percent over total encounters in 1988. These numbers reflect that homeless persons not only come for primary care, but return for ongoing care, in addition, over three hundred (300) volunteer physicians have provides specialty consultations to the homeless here in Washington. Seventy-five percent (75 percent) of the homeless patients kept their appointments.

The Health Care for the Homeless Project has demonstrated that it is possible to access the homeless for health care, but more resources are needed. The number of patients continues to grow and the severity of illnesses progressed. In Washington, we are not even beginning to meet the need. At the larger shelter of fourteen hundred (1,400), we begin signing patients up at 8:30 a.m. By 9:30, the list closes and the remainder of the patients are told to go to the emergency rooms. We will often see forty (40) or more patients in a half day. Many other shelters where we cannot provide health care go unserviced.

If the homeless are to survive, it is essential that they have access to health care. This is our humane duty, but health care for the homeless also keeps these persons out of expensive emergency rooms, hospitalizations and long-term placement.

Health Care for the Homeless Programs have also shown that it enables persons to leave homelessness and move into alternative settings. Christ House, a respite care facility where the sick homeless stay, has cared for over fifteen hundred (1,500) patients. Of those, sixty-seven (67 percent) percent were placed into alternative housing settings.

At Christ House for myself and the other physicians, it has been a privilege to work and live with those who are homeless. Many of the homeless are often very ill when they come to us. But during this crisis in their life, and during the recovery process, they sometimes discover their own giftedness, their own talents, and with support, begin to move into new settings. We regularly see persons who move into transitional housing, into jobs and then into permanent housing. One of these persons now works with us as a medical assistant.

The McKinney money for the homeless health care program has enabled care for many such homeless persons who otherwise would receive no care—and their money has been very effectively used. However, the amount has been far too little to meet the growing need. I urge the committee to consider increasing the authorization level in order that care may be provided for those who suffer greatly.

A play given on the grounds of the Capitol just before the McKinney legislation was passed contained a last line which said: "To be gravely ill and seriously impaired is devastating—to be gravely ill and seriously impaired and homeless is beyond the realm of imagination."

Mr. WAXMAN. Ms. Fleming.

STATEMENT OF MARY FLEMING

Ms. FLEMING. Good morning, Mr. Chairman.

I am the executive vice president of the Franklin County Alcohol and Drug Addiction Board in Columbus, OH. We are the organization that is responsible for mental health and substance abuse services. While I speak to you today on behalf of the homeless and mentally ill, I am most pleased to have the opportunity to talk with you about how my community is responding to the needs of homeless people with mental illness, in particular how the McKinney funds along with State, local and private dollars have helped in that effort.

As you probably know, of the estimated 3 million homeless people, approximately one-third suffer from mental illness and 40 percent use alcohol and/or drugs. As many as 50 percent may experience substance abuse and mental illness. In order to break the cycle of homelessness these individuals require a myriad of support services in addition to health care and other basic services. We find the problems to be complex and at times overwhelming requiring considerable coordination of policy and practice at the State and local level.

My testimony today concerns the renewal of mental health plans under the McKinney Act. The act contains an important provision designed for the mentally ill. The Mental Health Services for the Homeless, MHSH, Block Grant Program supplies funding so that States can establish comprehensive community services for homeless people who are mentally ill. Under this grant program, States are required to provide essential services such as outreach, community mental health treatment and rehabilitation services, case management, training of personnel who work with homeless people and referral for medical, substance abuse and residential services.

Grant awards are targeted toward the regions with the largest population of homeless people by distributing funds based on the State's urban populations.

States must contribute 25 percent of the cost of services.

Mental health professionals consider this program to be critical for providing comprehensive services to homeless people. We support the design of the MHSH program, a separate title under the McKinney Act, which insures that funds are targeted at homeless people who suffer from mental illness. Serving homeless individuals with mental illness is a challenging task because traditional treatment and rehabilitation methods do not work. The Federal Government must continue to encourage the innovative programs necessary to meet the needs of the increasing numbers of homeless men, women and children who suffer from mental illness.

According to a recent survey, 49 States reported servicing approximately 69,267 homeless mentally ill persons through the MHSH State grant program. Unfortunately, this figure represents only a fraction of the homeless people who need mental health services. States estimate that between 214,311 and 275,451 homeless Americans with mental illness are not served under the McKinney program and may not be receiving appropriate mental health services.

In addition to mental health services, States address the range of basic needs experienced by homeless people with mental illness, including primary health care. Homeless people often suffer from serious medical problems such as infectious diseases, open sores, and malnutrition. MHSH-funded programs are able to address the health needs of this group through referral, case management or services at the community health center. Thus, this far-reaching program attempts to integrate both the physical and mental needs of its clients.

In Columbus, we have worked to develop a range of services and support for homeless people. They are designed to be available in places where homeless people are and designed to offer flexible and varying levels of support. The array of services includes outreach teams designed to assist people in meeting their immediate basic life needs of food and shelter and clothing. Treatment teams are trained to work with people with particularly major mental illnesses, to engage them in treatment, to deal with the complex problems of going though counseling or psychiatric treatment. McKinney Act funds were used to augment this as a way of providing services to develop a medical outreach team headed by a psychiatrist in a unique partnership with our community mental health center.

We have labeled it our "Doc in Box" project, where a psychiatrist teams up with community mental health nurses to provide psychiatric and primary health care on the streets of Columbus and in the shelters. We are developing an enormous amount of resources for the development of permanent housing for homeless people. We are beginning to see the results of people getting the services they need to break the cycle of despair.

They are finding jobs and living in our communities as successful citizens. I am reminded of a particular client who cycled in and out of State prisons and State mental hospitals, major mental illness and substance abuse. Through a variety of outreach efforts he was able to finally get the kind of treatment that he wanted in addition to what we felt he needed and now lives in his own apartment and is working for the first time in his life. The man is 35 years old. He

is one example of the kind of person that we feel like we are beginning to have an impact on.

While the McKinney Act funding was absolutely critical to this, perceived unstable funding often makes it difficult for communities to start new programs. This is particularly true in areas where county mental health authorities do not have a strong local base of support and lukewarm, perhaps, State support.

By working through State mental health authorities I believe the McKinney Act funds are best leveraged effectively to develop a coordinated set of services which will continue in communities. It is awful to be a county administrator and start programs that you cannot be sure will continue. I believe the State authority would avoid that kind of situation.

On behalf of the various organizations I am here to represent, I would like to make the following recommendations. I recommend that you increase the authorization level to $100 million for the mental health services to the homeless State grant program. This figure represents the original authorization level in 1987 when lawmakers recognized the wide spread need for such funds.

The need for specialized services has grown since the law was passed. The treatment and support technologies are available for people. We need to make them accessible to larger segments of the population. States will be ready to utilize these extra funds quickly since they have already established their programs and identified the unmet needs in their areas.

We further recommend provisions be stricken which prohibit using mental health services to homeless grant money in HUD supported housing. Currently the legislative language is unnecessarily restrictive and prevents innovative and creative program financing. Permission to use it will promote more comprehensive and coordinated service systems.

I further recommend we prohibit service providers from discriminating against individuals who are dually diagnosed. They represent a part of the population and I don't think we should shy away from them. A new clause should prohibit States from awarding grants to service providers which have one, a policy or practice of excluding individuals from mental health services due to the existence or suspicion of substance abuse or, two, a policy or practice of excluding individuals from substance abuse services due to the existence or suspicion of mental illness. This addition does not require each provider to directly serve all applicants but the provider must have the capability to see that the individual is served, either directly, through contract, or by referral. The new provision will increase the availability of services to a particularly challenging population.

Renew the authority for the Community Mental Health Demonstration projects. These demonstration projects have proven to be extremely valuable in learning how to assist homeless people with mental illness. Innovative approaches have been developed with demonstration grants which will enhance the ability of States to serve this group of homeless individuals. However, service providers are still not reaching a majority of homeless people with mental illness. Clearly, the mental health demonstration projects

must continue in order to develop new approaches for treating people who are mentally ill and homeless.

Mr. Chairman, I appreciate the opportunity to present the successes of the MHSH Block Grant Program and explain the remaining unmet needs of people who are homeless and mentally ill. During this reauthorization process, an important opportunity exists to improve the MHSH program. Many homeless people with mental illness depend on the subcommittee's actions to expand the MHSH program and allow them access to basic services. Your efforts to provide for this vulnerable population are greatly appreciated.

Mr. WAXMAN. Thank you very much for your testimony.

[The prepared statement of Ms. Fleming follows:]

PREPARED STATEMENT OF MARY FLEMING, EXECUTIVE VICE PRESIDENT, FRANKLIN COUNTY MENTAL HEALTH BOARD

Mr. Chairman, my name is Mary Fleming and I am the Executive Vice President of the Franklin County Mental Health Board in Columbus, Ohio. I speak to you today on behalf of homeless people with mental illness and several organizations which advocate for their needs: the National Association of State Mental Health Program Directors, National Alliance for the Mentally Ill, National Mental Health Association and the Mental Health Law Project.

It saddens me to report that, tonight, many men, women and children will not have a place to call home. Despite increased public attention, the problem of homelessness is growing. Estimates of the number of homeless people range up to 3 million. Unfortunately, for many of those individuals, the issue of homelessness is compounded by other serious conditions. Approximately 30 percent of homeless people suffer from mental illness. This group requires not only shelter but mental health services to address their illness. Another serious problem is the existence of substance abuse among homeless people. Local officials report that 44 percent of homeless people abuse alcohol or drugs. Finally, studies reveal that many homeless individuals, perhaps up to 50 percent, experience both substance abuse and mental illness. These individuals face a daunting battle to overcome their substance abuse, mental illness and homelessness. Clearly, these statistics indicate the magnitude of this complex problem.

My testimony today concerns the renewal of the mental health programs under the McKinney Act. As you know, the Stewart B. McKinney Homeless Assistance Act (P.L. 100–77 as amended by P.L. 100–628) contains an important provision designed for people with mental illness. The Mental Health Services for the Homeless [MHSH] Block Grant Program supplies funding so that states can establish comprehensive community services for homeless people who are mentally ill. Under this grant program: States are required to provide essential services such as outreach, community mental health treatment and rehabilitation services, case management, training of personnel who work with homeless people and referral for medical, substance abuse and residential services; grant awards are targeted toward the regions with the largest population of homeless people by distributing funds based on the state's urban population; and States must contribute 25 percent of the cost of the services.

Mental health professionals consider this program to be critical for providing comprehensive services to homeless people. We support the design of the MHSH program, a separate title under the McKinney Act, which insures that funds are targeted at homeless people who suffer from mental fitness. Serving homeless individuals with mental illness is a challenging task because traditional treatment and rehabilitation methods do not work. The federal government must continue to encourage the innovative programs necessary to meet the needs of the increasing numbers of homeless men, women and children who suffer from mental illness.

According to a recent survey, 49 states reported serving approximately 69,267 homeless mentally ill persons through the MHSH state grant program. Unfortunately, this figure represents only a fraction of the homeless people who need mental health services. States estimate that between 214,311 and 275,451 homeless Americans with mental illness are not served under the McKinney program and may not be receiving appropriate mental health services.

In addition to mental health services, states address the range of basic needs experienced by homeless people with mental illness, including primary health care. Homeless people often suffer from serious medical problems such as infectious diseases, open sores and malnutrition. MHSH-funded programs are able to address the health needs of this group through referral, case management or services at the community health center. Thus, this far-reaching program attempts to integrate both the physical and mental needs of its clients.

In order to implement the MHSH program, states had to overcome several hurdles. Perhaps the biggest obstacle was the unstable funding stream received from the federal government. Overall, the combined appropriation for the MHSH block grant in fiscal year 1987 and 1988 was $43.689 million. However, this figure dropped to $14.128 million in fiscal year 1989. Several MHSH sponsored programs were forced to shut down due to the dramatic funding cuts. The states of California and New York provide good examples of the drastic fluctuations: in the original appropriations, the states received $6,073,586 and $3,760,833 respectively. However, in fiscal year 1989, both states received $267,944. Providing consistent and comprehensive services in this fiscal environment is not easy.

In addition, states faced the challenge of securing the necessary approvals from various state agencies and local providers and locating matching funds from stretched state budgets before implementing the required programs. Despite these obstacles, states were able to provide vital services to homeless people with mental illness. In fact, some states demonstrated a major commitment to the program through their state match. For instance, California appropriated $20 million each year for its state match, despite the inconsistent federal funding. Indeed some states met their responsibility to this federal program to a greater extent than the federal government did.

CURRENT USE OF MHSH BLOCK GRANT PROGRAM

Although this program is labeled as a block grant program, states are required to follow strict guidelines when utilizing the funds. In fact, the MHSH program strongly resembles a categorical grant program since it specifically targets a narrow population. One benefit of this structure is that states understand what services must be provided with grant funds. As a result, policymakers can evaluate how important resources are being spent. As the following information demonstrates, the program generates a wide range of vital and innovative services to reach homeless people with mental illness.

SERVICES PROVIDED WITH MCKINNEY MONEY

The six services required by the MHSH program were designed to provide comprehensive services to homeless people with mental illness. Many states, including the following, implemented a variety of innovative approaches to assist this group.

Outreach

A Minnesota county conducted outreach by hiring a worker to travel the back roads in search of homeless persons staying in parks, abandoned buildings and rest stops.

A mobile mental health treatment team in Rhode Island provided outreach, mental health services, diagnosis, crisis intervention, case management and supportive residential services wherever homeless persons were contacted.

Maine established two outreach programs to serve homeless youth; one based at a group home and one at a counseling program.

Case Management

Idaho implemented an intensive case management program, including outreach, assessment, coordination of services, advocacy and contact with clients' families. In addition, case managers documented obstacles in the system which hindered clients from obtaining services and searched for solutions to these problems.

Oregon retained homeless individuals in ongoing mental health services through its unique case management program in order to prevent recurrent homelessness.

Community Mental Health Services

New York contributed to the development of a self-help day center which provided peer support and socialization, meals and referral for mental health services.

In West Virginia, a day treatment program was created to provide training in daily living skills and referral for vocational services.

Arkansas instituted a crisis intervention system, including a 24-hour telephone information and referral program, on-call crisis workers and seven 24-hour care non-hospital beds.

Supportive Residential Settings

Delaware developed transitional/respite services by setting aside four beds in a treatment facility for people requiring intensive, short-term respite and eight beds in the community for longer respite.

West Virginia established eight specialized adult foster care homes and incorporated intensive training of foster care providers and extensive followup.

An Oklahoma shelter was expanded by 18 beds reserved for homeless persons experiencing mental fitness and substance abuse and developed short-term emergency housing for homeless persons who were not appropriate for existing crisis beds.

Training

New York organized a peer-outreach program which provided training to service providers.

An Ohio county hired a professional to institute and evaluate training programs for police, hospital staff, social service agency staff and consumers.

Consumer Involvement

An innovative consumer case management aide program in Colorado hired aides who had experienced major mental illness and homelessness to provide services.

Idaho promoted the formation of a family support group, a self-advocacy/consumer education group and a mobile consumer-outreach group.

In Ohio, mental health consumers ran an assistance network which included an outreach team.

IMPROVING THE LIVES OF MENTALLY ILL HOMELESS PEOPLE

The preceding services are critical if the states hope to combat mental illness among people who are homeless. The following stories describe the successful engagement of several individuals. These "success stories" can be attributed to dynamic state and local programs, caring personnel and federal funding under the MHSH grant program. However, the vignettes represent only a small fraction of the people who could benefit from expanded housing and mental health services.

After cultivating a trusting relationship with A.M. a homeless man living in a dumpster, workers from air assertive outreach/case management program arranged for him to obtain appropriate psychiatric care, housing, glasses and critical medical care. Now living in a supervised residential arrangement, A.M. is learning daily living skills and receiving other mental health services so he can move into an independent setting shortly.

The county jail referred M.K. to an outreach team after his detention for disturbing the peace and displaying disruptive behaviors. Diagnosed with schizophrenia, M.K. had no home or connections in the community. The team discovered he was a voluntary patient elsewhere in the state and had wandered away from the hospital. The outreach team referred the man to the city mission so he could receive emergency medication. In addition, the team obtained a bus ticket through donated Salvation Army funds, monitored his stay at the mission, provided transportation to the bus station and arranged for a case manager to meet M.K. when he returned to his community.

M.S. had been released from a psychiatric inpatient unit with a diagnosis of bipolar mood disorder and was residing at a city mission. Instead of slipping through the cracks of a fragmented delivery system, M.S. was admitted to a specialized adult foster care program and placed in a home according to her residential preferences. Supportive housing plus a day treatment program have stabilized the woman's psychiatric condition. Recently, she has resumed supervised visits with her children.

Family violence and neglect forced M.G., age 17, onto the streets. She stayed in a short-term emergency facility while efforts were made to return the young woman to her family. Unfortunately, these attempts failed. However, M.G. was admitted to a specialized community program for homeless adolescents. Mental health workers identified a foster parent to be a mentor and trained the foster family to insure a smooth placement. This setting should provide a healthy environment for M.G. and allow her to mature without the risk of homelessness.

SERVING HOMELESS PEOPLE WITH MENTAL ILLNESS: ONGOING ISSUES

While many advances have occurred with MHSH grant money, several issues continue to plague the service delivery system designed to help this challenging popula-

tion. A primary problem is the lack of integration between housing and supportive services at the federal, state and local levels. These two critical components must be coordinated in order to enhance the ability of service providers to provide comprehensive services to homeless people with mental illness. Currently, providers are forced to piece together programs from a variety of federal funding streams. This fragmentation at the federal level results in a splintered system at the state and local levels. More importantly, a "band-aid approach" creates unnecessary confusion for the very population needing assistance, homeless persons with mental illness. The need to integrate housing and services when serving homeless people with mental fitness is still a pressing issue.

In addition, concern is rising about services to homeless persons who are dually diagnosed as having both mental illness and substance abuse problems—both alcoholism and addiction. The estimates of homeless people who suffer from either alcoholism and drug addiction and mental illness is increasing. However, few programs exist to treat the substance abuse problems of mentally ill homeless people. Many mental health providers do not have the capacity to serve people who also use alcohol or drugs. Similarly, substance abuse treatment programs maintain they cannot serve clients who are mentally ill. However, these people have no where else to turn and are often forced back on the streets because of lack of treatment alternatives. Given the strong overlap between homeless people who suffer from mental illness and substance abuse, the absence of suitable treatment facilities for the dually diagnosed must be addressed.

RECOMMENDATIONS

On behalf of NASMHPD, NAMI, NMHA and MHLP, I urge the Subcommittee to build upon the past success of the MHSH State Grant Program by implementing the following recommendations:

(1) *Increase the authorization level to $100 million for the MHSH State Grant Program.* This figure represents the originally proposed authorization level in 1987 when lawmakers recognized the widespread need for such funds. Indeed, the need for specialized services has grown since the original law was passed. The recommended increase is based on the recognition that the present authorization level of $35 million is inadequate to provide the necessary services to the current target population. Currently, states are only able to serve 20 percent of the homeless population with mental illness. A funding level of $100 million could dramatically improve that alarming percentage and enable up to 87 percent of those who require services to receive them. States will be ready to utilize these extra funds quickly since they have already established their programs and identified the unmet needs in their area. As no other federal support programs are targeted at the unique needs of homeless people with mental illness, this increase is imperative to reach the majority of homeless people with mental illness who now are falling through the cracks of the social service system.

(2) *Strike provisions which prohibit using MHSH Grant Money to provide services in HUD supported housing (Sec. 524(a)6(A) and (B)).* Currently, the legislative language is unnecessarily restrictive and prevents innovative and creative program financing. Permission to utilize HUD or other McKinney money will promote more comprehensive service systems.

(3) *Prohibit service providers from discriminating against homeless individuals who are dually disposed.* A new clause should prohibit states from awarding grants to service providers which have (a) a policy or practice of excluding individuals from mental health services due to the existence or suspicion of substance abuse or (b) a policy or practice of excluding individuals from substance abuse services due to the existence or suspicion of mental illness. This addition does not require each provider to directly serve all applicants but the provider must have the capability to see the individual is served, either directly, through contract, or by referral. The new provision will increase the availability of services to a particularly challenging population.

(4) *Renew the authority for the Community Mental Health Demonstration projects.* These demonstration projects have proven to be extremely valuable in learning how to assist homeless people with mental illness. Innovative approaches have been developed with demonstration grants which will enhance the ability of states to serve this group of homeless individuals. However, service providers are still not reaching a majority of homeless people with mental illness. Clearly, the mental health demonstration projects must continue in order to develop new approaches for treating people who are mentally in and homeless.

Mr Chairman, I appreciate the opportunity to present the successes of the MHSH Block Grant Program and explain the remaining unmet needs of people who are homeless and mentally ill. During this reauthorization process, an important opportunity exists to improve the MHSH program. Many homeless people with mental illness depend on the Subcommittee's actions to expand the MHSH program and allow them access to basic services. Your efforts to provide for this vulnerable population are greatly appreciated.

Mr. WAXMAN. Professor Wright, you testified that the rates of tuberculosis and HIV infection among the homeless exceed those in the general population by a factor of roughly 100. This is truly a terrifying statistic.

What are the infection rates and why are they so high?

Mr. WRIGHT. The TB infection rate among the homeless has been variously estimated to run anywhere from 500 to 600 per 1,000 to 3 to 5 percent of the homeless population. The screening programs in New York City uncovered active TB infections in about 2 percent of the clients, that would be 2,000 per 100,000.

In the Nation as a whole the rate of tuberculosis infection is in the order of 10 cases per 1,000. The general level of debilitation among homeless people makes them susceptible to all sorts of infectious disease.

The conditions in the shelters provide optimal conditions for the transmission of contagious diseases. With hundreds of men living in close quarters, infections can move around easily. It has been said with some justification that the rate of tuberculosis is the single best indicator of the living conditions of the poor.

The rate of tuberculosis among the homeless indicates how far we have allowed the situation to generate. The HIV infections are harder to estimate. The only real data that I have on it is now 3 years old. With the rate of infectivity increasing so dramatically I am sure these numbers are no longer correct, but as of 3 years ago my estimate was 300 to 400 cases per 100,000 HIV infections compared to 20 per 100,000 in the U.S. population as a whole.

Most of the HIV infectivity among the homeless appears to be drug related rather than sexually transmitted. The rate of drug abuse specifically among homeless men runs somewhere around 10 to 15 percent, an enormously large pool of potential for the spread of HIV virus in this population.

Mr. WAXMAN. The Center for Disease Control has over $300 million for AIDS education and risk reduction programs. Members of the panel, have any of your 340 programs been able to use these funds? Have they been able to carry out such activities on their own?

Ms. CLOTHIER. With our program we are able to treat HIV problems on our own. We are appreciative to be able to tap into a lot of resources made available to us. The best one was special training for our physicians who are involved in this treatment process.

Ms. GOETCHEUS. There have been several groups here in Washington who have participated in preventive outreach in the shelters.

I think what we face most as physicians is that the money has not been allowed to be used toward direct services. Although we have the preventive aspect going on and we are involved with that personally on a one-to-one basis and we are showing videos in the

soup kitchens, there has not been enough money for us to provide the physicians in the shelters who specialize in this.

We used to have them only on Wednesday but we were soon swamped. Now we see them throughout the week. The money for direct medical care has been limited for us.

Ms. FLEMING. The outreach and prevention efforts have been handled through the existing programs. We have not accessed any new money for that. We have worked as part of a national oriented system through the existing systems as they are.

Mr. WAXMAN. As you know, CDC makes $8 million available to States for tuberculosis control. Have any of your 340 programs been able to tap into these funds and have they been able to undertake TB prevention and control activities?

Ms. GOETCHEUS. I don't know that we have received any direct money for TB. That may have gone directly into the program that D.C. has rather than into the Health Care for Homeless program.

But if we had such, as Jim mentioned, our real problem is that these people are discharged back to the shelters. They are seen in emergency rooms and diagnosed and maybe admitted for a couple of weeks.

But there is no housing for them. They come back to the shelter. They quickly get off their medication, they get off not eating properly and they cough through the night and the person sleeping next to them gets tuberculosis. In terms of treatment we can send them to the TB center in Washington.

They can get medications and a chest x-ray but they are still out on the street.

Ms. CLOTHIER. CDC money almost exclusively goes into State government. Therefore, it is subject to the priorities and sophistication of each of the individual States in terms of how their programs are developed.

In areas of the country that I have heard about that have good programs that have developed statewide, it is very easy to access folks into the State TB programs.

In States that I am more familiar with where there has not been a good program developed then there is really no assistance from that quarter.

Mr. WAXMAN. Dr. Goetcheus, you testified that when you asked your patients where they would go if the project were to close, most said they would go to the emergency room. Do you and the other panelists know if this is the experience for health care in other cities?

Ms. GOETCHEUS. I think it is true not just for the homeless. I think it is true for those who are poor and under insured across the United States. I think that is one reason why we see the high mortality rates among minorities because their primary access has been to the emergency room.

In urban areas after being seen in that emergency room they may be referred back to one of the hospital's outpatient clinics which are in a teaching setting. There they will be seen by a different doctor every time they go. They become discouraged and they quit going. We have reaped the results of that in terms of high morbidity and mortality rates in almost any illness that I can mention.

Ms. FLEMING. I think for homeless people or mentally ill, even going to an emergency room becomes a problem. They lack the resources and ability to do that. Without such programs, the particular population I am interested in would suffer incredibly. They would either die or end up in State hospitals or jails. That is where they would go.

Mr. WRIGHT. Mr. Chairman, any number of studies have shown that in the absence of targeted health care programs such as McKinney, homeless people would do without health care or go overwhelmingly to the emergency room. That tends to be true of the poor.

In New Orleans, the largest city that does not fund a municipal shelter, the homeless people use the emergency room of charity hospital as an overnight shelter. It was explained to me it is the one place in the city you can go and expect to sit for 5 or 6 hours and not have anybody bother you.

Mr. WAXMAN. Ms. Clothier you mentioned that in the most recent funding cycle a number of 340 projects were forced to terminate substance abuse treatment contracts. Why did this happen and what was the result for homeless patients with substance abuse problems? Were they able to find treatment services elsewhere?

Ms. CLOTHIER. For the record, I think we are all aware of what happened with the appropriations with the McKinney programs over the last couple of years. The substance abuse programs were victims of that. For those of us who are running both physical health and mental health programs, when the funding is reduced close to 50 percent, then we have to make the hard choice of whether or not someone is going to live or die before we start worrying about the quality of their life.

There is no other real availability of help for the homeless except with the special targeted programs. In the few cases that we are aware of where there is available space in more traditionally funded programs but they are hard too.

Mr. WAXMAN. This is a question for anyone on the panel or all of you. Last fall in OBRA 1989 Congress amended the Medicaid law to require the States to cover services delivered by "340" programs to homeless individuals who are eligible for Medicaid.

That requirement was effective on April 1 of this year.

What has the implementation experience been so far? Are States complying? Are you receiving 100 percent of the reasonable cost of your services to Medicaid-eligible homeless people? What proportion of the people that you serve are eligible for Medicaid?

Ms. CLOTHIER. I would like to respond to that. The new law is certainly going to be of great assistance for us over time. As you may be aware, however, the implementation of that is falling to each of the States to design their own administration.

The States have until June 30 to decide what their plan is going to be. So we have not yet seen the dollars. We expect that for those who are eligible for Medicaid obviously going from 78 or 79 percent reimbursement to 100 percent reimbursement is delightful.

Having the expanded service package will also help. However, you need to be aware that there are many places still around—Indiana is one of the greatest examples—where, if you are not a preg-

nant female or child age 6, you must be below 38 percent of the poverty line to be on Medicaid.

Then you have, again, to be a parent with a dependent child or completely physically disabled. Medicaid is not a good reimbursement source for health care for the homeless except for the women and children. There is a problem, I believe, nationwide, with the implementation of disability programming under Medicaid.

All of our homeless persons should be eligible for disability under Medicaid and social security. Quite frankly, we are having to refer our homeless clients to the legal appeals process to try and get them on those programs and it is not happening.

Ms. GOETCHEUS. Our experience would be the same. The mothers through AFDC are eligible for Medicaid. Outside of that less than 10 percent of our patients are eligible for Medicaid. The only way that someone would become eligible for Medicaid here in the District as a single individual would be to go through the SSI process.

As I mentioned, that is a horrendous process to go through. The only way we get involved is through the appeal process and getting attorneys involved. It is very hard to prove on paper what has happened to a 50-year-old man who has experienced poverty most of his life, goes without any health care, probably can't read or write.

To try to prove that this person is truly disabled because he doesn't meet the criteria of one particular illness is very difficult. So less than 10 percent of our patients have Medicaid.

Ms. CLOTHIER. To underscore, in 1989 our total expenditures for our health care for the homeless program were roughly $400,000. Even though we had experienced a 500 percent increase in Medicaid members from 1988 to 1989, out of the $400,000 we spent in 1989, our Medicaid reimbursement was right at $5,000.

Mr. WAXMAN. Ms. Fleming.

Ms. FLEMING. Our population is a little different. We find we are able to entice onto Medicare or SSI approximately 40 to 50 percent of the people with major mental illness who agree to engage in services. The problem is that many people really don't want to do that. It takes a very long period of time. If you have a system set up that makes it hard for people to get their benefits and it has taken you a year and a half to convince them they would benefit from being on SSI and then they have to go through a 180- or 200-day waiting period, you have lost the confidence that you have gained in the process.

It is a hard process to go through.

Mr. WAXMAN. When the McKinney Act was first considered, it was thought that providing for the health care needs of homeless persons could best be accomplished by designating a single provider to be responsible for primary care, substance abuse, and mental health services. But under current law, mental health services are provided through a small State block grant, while primary health and substance abuse services are provided through categorical grantees. Do you continue to believe the health care needs of the homeless population should be provided through two separate systems, Ms. Fleming?

Ms. FLEMING. Yes, I do. I believe in most States the State mental health authority has the major pot of money in mental health serv-

ices and has the best ability to sort of use funds leveraged against other accounts.

I believe that mental health is really primarily a State driven activity. I am very fortunate because we have a large local base of support for mental health services. That is rather unique. It is State dollars in there. I think to get the best use of Federal dollars they really need to go through the State mental health authority.

Mr. WAXMAN. Given the historically low level of funding that has been provided States through the Homeless Mentally Ill Block Grant, would it not further your objectives if the care of homeless mentally ill persons was made a State requirement for receiving funds under the larger Alcohol, Drug Abuse, and Mental Health Services Block Grant?

Ms. FLEMING. I had not thought about that. I think States should be able to plan for and provide mental health services to homeless persons. Our State does allow us to plan for and provide those services. I think that should be encouraged.

Mr. WAXMAN. The sum of $27 million was appropriated for the Homeless Mentally Ill Block Grant in fiscal year 1990, also $240 million was available for mental health services under the larger ADMHS Block Grant. That is why I was interested in your reaction to it.

You have testified that grant awards under the homeless program are targeted toward the regions with the largest populations of homeless people. In fact, this is not always the case. In 1989, California and New York received exactly the same allocation as Alaska and Wyoming. In 1990, more than half the States received the same allocation. The explanation for this is a statutory requirement that each State, regardless of size or homeless population, receive a minimum allocation of $275,000. Would you support reducing the minimum allotment to provide more equitable distribution of funds between States?

Ms. FLEMING. I would support increasing the total authority for the act to ensure that services that are needed are provided. I would support no reduction in the act.

Mr. WAXMAN. Thank you.

I want to thank each of you for your participation in this hearing. This record will be very helpful to us in explaining to our colleagues why we should go forth with this much needed legislation.

I thank you for being here. That concludes the business of the subcommittee for this hearing and we stand adjourned.

[Whereupon, at 10:45 a.m., the hearing was adjourned.]

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